

5

Reg. Dist. No.

5

1. PLACE OF DEATH o. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Walter Winslow Abin		4. DATE OF DEATH Month Day Year 6/19/1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/13/1902
9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter	
11. BIRTHPLACE (State of foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry L. Abin		14. MOTHER'S MAIDEN NAME Agnes Jones	
15. WAS DECEASED EVER IN U. S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. 217-12-8248	
17. INFORMANT Mrs. Edna Moore		Address Middletown, Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Massive Myocardial Infarction DUE TO (c) Coronary Occlusion PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous Coronary Artery Disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Syncope	
20c. TIME OF INJURY Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1956, to 6/19/1957, that I last saw the deceased alive on 6/19/1957, and that death occurred at 9 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Wallace Oberstein		DATE SIGNED 21 June 57	
PHYSICIAN'S NAME (Type) Wallace Oberstein		ADDRESS (Street, city or town, state) Cecil, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/22/57	
22c. NAME OF CEMETERY OR CREMATORY Warwick		22d. LOCATION (City, town, or county) (State) Warwick Ind.	
23. FUNERAL DIRECTOR'S SIGNATURE G. L. Smith		24a. REC'D BY REGISTRAR DATE 6/21/57	
ADDRESS Middletown, Del.		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 25 1957

RECEIVED

6210

CERTIFICATE OF DEATH

06191

Reg. Dist. No.

96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Perryville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Sarah Anderson		4. DATE OF DEATH Month Day Year June 30 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1872
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Daniel Howllway		14. MOTHER'S MAIDEN NAME Francis Billings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Morris Anderson		Address Perryville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Cerebral Sclerosis (b) Arterio-Sclerosis - (c) Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 months 5 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 334X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 25 - 1956 to June 29, 1957 that I last saw the deceased alive on June 29, 1957, and that death occurred at 2:20 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Fort Belvoir, Md. DATE SIGNED 11/1/57	
ACTUAL SIGNATURE Clarence L. Benson		PHYSICIAN'S NAME (Type) CLARENCE L. BENSON	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 3 1957	
22c. NAME OF CEMETERY OR CREMATORY Brookview Cem.		22d. LOCATION (City, town, or county) (State) Rising Sun Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson		ADDRESS Rising Sun, Md.	
24a. REC'D BY REGISTRAR DATE JUL 2 1957		24b. REGISTRAR'S SIGNATURE Jesse Daugherty	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JUL 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6211

CERTIFICATE OF DEATH

06192

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen 12312 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			d. STREET ADDRESS Bush Chapel Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALFRED Middle (NMI) Last BATTLE			4. DATE OF DEATH Month June Day 13 Year 19 57		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-1-95	9. AGE (In years lost birthday) yrs. 62	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurants		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Richard Battle		
14. MOTHER'S MAIDEN NAME Sophie (?)			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		
16. SOCIAL SECURITY NO. unknown			17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, uremic poisoning 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic glomerulonephritis DUE TO (c) unknown					INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 Arteriosclerosis, general, severe - unknown					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from May 16, 19 57, to June 13, 19 57, and that death occurred on June 13, 19 57, at 3:55 a.m., from the causes and on the date stated above.					
ACTUAL SIGNATURE W. Oppler		M.D. V.A. Hospital, Perry Point, Md. 6-13-57			
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-16-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary	
22d. LOCATION (City, town, or county) Aberdeen, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Tarring Funeral Home, Aberdeen, Md.		24a. REC'D BY REGISTRAR June 17-57		24b. REGISTRAR'S SIGNATURE Willie G. Perry	

STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

RECEIVED
JUN. 19 1967
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06193

6212

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last WALTER L. BEAUCHAMP		4. DATE OF DEATH Month June Day 16 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-16-95
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Signalman		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania R.R.	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Tubman T. Beauchamp		14. MOTHER'S MAIDEN NAME Mary Long	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 717-07-5297	17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 203x Bronchopneumonia, bilateral, unresolved DUE TO (b) Plasma cell myeloma lumbar vertebra DUE TO (c) unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 72 to 96 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 Arteriosclerosis, general, moderate - unknown			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 6, 19 57, to June 16, 19 57, and that death occurred at 7:15 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 6-17-57	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal	22b. DATE THEREOF 6-17-57	22c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery	22d. LOCATION (City, town, or county) (State) Perryman, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son, Perryville, Md.		24a. REC'D BY REGISTRAR DATE 6-17-57	24b. REGISTRAR'S SIGNATURE Irene E. Langley

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06194

6196

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <u>USA Cecil</u> MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton One day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 North East</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		d. STREET ADDRESS <u>R.F. #1</u>	
3. NAME OF DECEASED (Type or print) <u>Newborn Baby - BENDER</u>		4. DATE OF DEATH Month <u>6</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-17-57</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) yrs. <u>7</u> Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>57</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Elkton Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James A. Bender</u>	
14. MOTHER'S MAIDEN NAME <u>Dorothy White</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>James A. Bender R.D. #1 North East Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abortion (650.1) For Medical Reasons</u> 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Delivery Complicated by Antepartum Hemorrhage</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 1/2 mos Gestation - Preeclampsia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Clifton R. Brooks</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-21-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bellevue Manor Memo Pk</u>		22d. LOCATION (City, town, or county) (State) <u>R.P. Elkton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry Paffin</u> ADDRESS <u>Elkton Md</u>		24a. REC'D BY REGISTRAR DATE <u>6/21/57</u>	
24b. REGISTRAR'S SIGNATURE <u>H. J. J. J.</u>			

2065242XVO

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. 3

JUN 24 1957

RECEIVED

6213 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colora Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colora Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Haines</u> Last <u>Blackburn</u>		4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 5 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Cecil Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Blackburn</u>		14. MOTHER'S MAIDEN NAME <u>Mary Rebecca Ferguson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Louisa Blackburn</u>		Address <u>Colora, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>General arteriosclerosis</u> DUE TO (c) <u>General arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>3 yrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/12</u> , 19 <u>57</u> , to <u>6/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/14</u> , 19 <u>57</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.		ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u> DATE SIGNED <u>6/16/57</u>	
PHYSICIAN'S NAME (Type) <u>Neil Taylor</u>		<u>Rising Sun, Md</u> <u>6/16/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 17 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham</u>	22d. LOCATION (City, town, or county) (State) <u>Near Colora Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Earl Tyson</u>		ADDRESS <u>Rising Sun, Md</u> 24a. REC'D BY REGISTRAR DATE <u>JUN 18 '57</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 18 1967

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6197

CERTIFICATE OF DEATH

06196

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Becil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hermitage Drive		d. STREET ADDRESS Hermitage Drive	
3. NAME OF DECEASED (Type or print) First Marie Middle S. Last CAVVICO		4. DATE OF DEATH Month June Day 19 Year 1957	
5. SEX F	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1877
9. AGE (In years lost birthday) yrs. 80		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY House Wife	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Wenzel Schuldtes		14. MOTHER'S MAIDEN NAME Catherine Wolf	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Betty Minster		Address Elkton, Md.	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Coronary Heart Disease DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 16 yrs 15 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JAN 1954 to 6/19/57 , 19____, that I last saw the deceased alive on 6/18/57 , 19____, and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George F. Kreiss, Jr. M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Elkton, Md. 6/22/57	
PHYSICIAN'S NAME (Type) George F. Kreiss, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-21-1957	22c. NAME OF CEMETERY OR CREMATORY Catholic Cemetery	22d. LOCATION (City, town, or county) (State) Elkton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Pippin		24a. REC'D BY REGISTRAR DATE 6/22/57	
ADDRESS Elkton, Md.		24b. REGISTRAR'S SIGNATURE 71, 500-201	

BUREAU V. S.

JUN 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06197

6198

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 20 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 24 Kent Rd.			
3. NAME OF DECEASED (Type or print) First Middle Last Salvador Crespedes				4. DATE OF DEATH Month Day Year 6 24 1957			
5. SEX M	6. COLOR OR RACE Wh.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1915	9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Assembly				10b. KIND OF BUSINESS OR INDUSTRY Chrysler Plant		11. BIRTHPLACE (State or foreign country) Spain	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Juan Cespdes Garcia				14. MOTHER'S MAIDEN NAME Juanita Garcia			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) W. W. # 2				16. SOCIAL SECURITY NO. 219-07-2377			
17. INFORMANT Catherine Cespdes				24 Kent Rd. Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction, small bowel 510.5 DUE TO Abdominal adhesions Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 577X INTERVAL BETWEEN ONSET AND DEATH 13 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/11 , 19 57 , to 6/24 , 19 57 , that I last saw the deceased alive on 6/11 , 19 57 , and that death occurred at 5:12 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 138 West Main St. Elkton, Maryland DATE SIGNED 6/24/57							
ACTUAL SIGNATURE John A. Fischer, M.D.							
PHYSICIAN'S NAME (Type) John A. Fischer							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6-28-1957			
22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery				22d. LOCATION (City, town, or county) (State) Elkton, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Saffin				24a. REC'D BY REGISTRAR DATE 6/27/57			
ADDRESS Elkton Md.				24b. REGISTRAR'S SIGNATURE			

RECEIVED

JUN 29 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6214

CERTIFICATE OF DEATH

06198

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland - Cecil County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-North East		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East-Rural L	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hosp-Elkton, Md		d. STREET ADDRESS North East-Rural L	
3. NAME OF DECEASED (Type or print) Ada Mrs Ada D. Cellings		4. DATE OF DEATH Month June Day 13 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1880
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) North East, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Samuel Hoffman		14. MOTHER'S MAIDEN NAME Mary Alexander	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio Vascular Renal Disease DUE TO (c) Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gangrene of Rt. foot with amputation thigh May 10, 1957			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 3, 19 57 to June 13, 1957 , that I last saw the deceased alive on June 12, 1957 , and that death occurred at 4.10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) North East, Maryland DATE SIGNED June 14/57			
ACTUAL SIGNATURE H. Arthur Centwell M.D. North East, Maryland June 14/57			
NAME (Type) H. Arthur Centwell, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6-16-57	22c. NAME OF CEMETERY OR CREMATORY Methodist	22d. LOCATION (City, town, or county) (State) North East Md
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Shant		24a. REC'D BY REGISTRAR DATE 6-16-57	24b. REGISTRAR'S SIGNATURE H. A. Centwell

RECEIVED

JUN 18 1957

BUREAU V. M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6215

CERTIFICATE OF DEATH

06199

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland		c. LENGTH OF STAY IN 1b 34 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		d. STREET ADDRESS None	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HOWARD Middle F. Last CULLUM		4. DATE OF DEATH Month 6 Day 16 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-26-92
9. AGE (In years last birthday) yrs. 65		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY General Contracting	
11. BIRTHPLACE (State or foreign country) Aberdeen, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert F. Cullum		14. MOTHER'S MAIDEN NAME Maggie Hamer	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT VA HOSPITAL RECORDS, VAH, PERRY POINT, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Enteric Fistula DUE TO Complicating Subtotal Gastric Resection For Bleeding Gastric Ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Unk. (c) Unk.		INTERVAL BETWEEN ONSET AND DEATH Approx. 30 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac Arrhythmia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. VA 19 57 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-13-57 to 6-16-57 and that death occurred at 12:15PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE E. S. Ellis, MD M.D.			
PHYSICIAN'S NAME (Type) E. S. ELLIS, M.D., Acting Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-19-57	
22c. NAME OF CEMETERY OR CREMATORY Wendover Chapel		22d. LOCATION (City, town, or county) (State) Aberdeen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Barling		24a. REC'D BY REGISTRAR DATE June 16, 1957	
24b. REGISTRAR'S SIGNATURE John E. Lacey			

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JUN 18 1957

BUREAU A. B.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06200

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 9 yrs. 1 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 400 West Saratoga	
3. NAME OF DECEASED (Type or print) JOHN FISCHER		4. DATE OF DEATH Month June Day 19 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-11-92
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 19 Days 19 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 217-07-116	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, right lower lobe, unresolved DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Encephalomalacia of frontal and temporal lobes, DUE TO due to arteriosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 4 - 5 days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, general, severe - unknown		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. VA 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19 , 19 48 , to June 19 , 19 57 , and that death occurred at 12:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md.	
PHYSICIAN'S NAME (Type) W. OPPLER		DATE SIGNED 6-20-57	
22a. BURIAL, CREMATION, REMOVAL Removal		22b. DATE THEREOF 6-20-57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Bennington & Son		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR DATE 6-21-57		24b. REGISTRAR'S SIGNATURE J. E. S. S.	

RECEIVED

JUN 25 1957

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6199

CERTIFICATE OF DEATH

06201

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1 RURAL</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>				d. STREET ADDRESS <u>1 ELKTON RFD # 3</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W</u> Last <u>FOSSETT</u>				4. DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 29, 1898</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____		IF UNDER 24 HRS Months _____ Days _____ Hours _____ Min _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JOHN T. FOSSETT</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE SCARBOROUGH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address <u>MRS. MAY FOSSETT ELKTON, MD. RFD # 3</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ATTACK</u> <u>H2H, 3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Duodenal diverticulum 5'</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>6:2</u> to <u>6:13</u> , 19 <u>57</u> , that I lost <u>saw</u> the deceased alive on <u>12:7</u> , and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John A. Jones, M.D.</u>				ADDRESS (Street, city or town, state) <u>138 W MAIN ST ELKTON MARYLAND</u>		DATE SIGNED <u>6/3/57</u>	
PHYSICIAN'S NAME (Type) <u>John A. Jones</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 6, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEWARK CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>NEWARK DEL.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. T. Jones</u>				ADDRESS <u>Newark, Delaware</u>		24a. REC'D BY REGISTRAR DATE <u>6/6/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

RECEIVED

JUN 7 1957

BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6217

CERTIFICATE OF DEATH

Reg. Dist. No.

06202

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia			
c. LENGTH OF STAY IN 1b 31yrs. 9mo. 26days							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2903 Richmond			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOHN Middle (M.I.) Last GILL			4. DATE OF DEATH Month June Day 20 Year 57				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-92		9. AGE (In years lost birthday) yrs 65		IF UNDER 1 YEAR IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Hospital records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema, severe G/OX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic heart disease, severe DUE TO (c) Peritonitis acute localized following prostatectomy							INTERVAL BETWEEN ONSET AND DEATH 24 hours unknown 48 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis general, severe - unknown							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year VA 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 25, 19 25, to June 20, 19 57, that I was the attending physician, and that death occurred at 3:05 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]			M.D. V.A. Hospital, Perry Point, Md.			DATE SIGNED 6-24-57	
PHYSICIAN'S NAME (Type) W. OPPIER			Director, Professional Services				
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-22-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Havre de Grace, Md.				24a. REC'D BY REGISTRAR DATE 6-26-57		24b. REGISTRAR'S SIGNATURE [Signature]	

BUREAU V. S.

JUN 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06203

6218

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Crisfield			
c. LENGTH OF STAY IN 1b 18 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS Route #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDGAR Middle F. Last GRAY			4. DATE OF DEATH Month June Day 10 Year 1957				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-24-88		9. AGE (In years, last birthday) 68 yrs.	IF UNDER 1 YEAR Months 6 Days 10	IF UNDER 24 HRS Hours 10 Min. 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Pete Gray				14. MOTHER'S MAIDEN NAME Kate Riffin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-01-4620		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Renal disease, type undetermined DUE TO (c) Unknown							INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. VA p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 23 , 19 57 , to June 10 , 19 57 , and that death occurred at 2:45 a.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Oepeler		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 6-10-57					
PHYSICIAN'S NAME (Type) W. Oepeler		Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-10-57		22c. NAME OF CEMETERY OR CREMATORY unknown		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw Funeral Home, Crisfield, Md.				24a. REC'D BY REGISTRAR DATE 6-10-57		24b. REGISTRAR'S SIGNATURE Edna H. H. H.	

RECEIVED
JUN 19 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6219

CERTIFICATE OF DEATH

06204

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Conowingo Md.</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Rural-Conowingo</u>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Graybeal</u> Last <u>Graybeal</u>		4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/8/1885</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Ash Co. North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Winton Graybeal</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-185606</u>	
17. INFORMANT <u>Mrs. Myrtle Graybeal Conowingo Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Arterio Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hr.</u> <u>2 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 12, 1957</u> to <u>June 12, 1957</u> , that I last saw the deceased alive on <u>June 12, 1957</u> , and that death occurred at <u>4:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. S. [Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>Baltimore Md.</u> DATE SIGNED <u>June 18 '57</u>	
PHYSICIAN'S NAME (Type) <u>A. S. [Signature]</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 13/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Hollingshead</u>	22d. LOCATION (City, town, or county) (State) <u>Cotter Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Earl [Signature]</u>		24a. REC'D BY REGISTRAR <u>June 18 '57</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

RECEIVED

JUN 18 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6220

CERTIFICATE OF DEATH

06205

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>2801 Jopley Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>J.</u> Last <u>GROSS</u>				4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-31-14</u>	9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Gross</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>217-07-1731</u>		17. INFORMANT Address <u>Hospital Records, VAH, Perry Point, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the stomach with metastasis</u> <u>151x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>o. 11.</u> Month <u>VA</u> Day <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 31</u> , 19 <u>57</u> , to <u>June 6</u> , 19 <u>57</u> , and that death occurred at <u>4:31 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. Oppler</u>				ADDRESS (Street, city or town, state) <u>V.A. Hospital, Perry Point, Md.</u>		DATE SIGNED <u>6-7-57</u>	
PHYSICIAN'S NAME (Type) <u>W. OPPLER</u>				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>6-7-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bennington & Son</u>				ADDRESS <u>Hayre de Grace, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6-7-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>James E. Langhorne</u>			

RECEIVED

JUN 11 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6221

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06206

Reg. Dist. No. 5

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton R.F.D. #4</u>				c. LENGTH OF STAY IN 1b <u>30 Min.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Hills, Md.</u>			
				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>Douglas W. G. Hammond</u>				4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>C.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 16, 1909</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Davis Hammond</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Irene Gale</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. 2 222-03-7387</u>		17. INFORMANT <u>Anthony D. Hammond</u> Address <u>Elkton RFD. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <u>7-15</u> Hour <u>6-15</u> p. m. <u>19 57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Creek</u>		20f. (City or town) <u>Blueball</u> (County) <u>Beid</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. C. Dodson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R. C. Dodson D. M. E.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 21, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>		22d. LOCATION (City, town, or county) <u>Nr. Northeast</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Piggan</u>				ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6/21/57</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. J. Piggan</u>	

RECEIVED

MAY 21 1957

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bellevue</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Deposit</i>	
		d. STREET ADDRESS <i>10 Race St.</i>	
3. NAME OF DECEASED (Type or print) <i>Sarah Rebecca Hopkins</i>		4. DATE OF DEATH <i>June 18 1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-6-1889</i>
9. AGE (In years last birthday) <i>68</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Carrie Jewe</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Edna Bethards</i>		Address <i>Port Deposit, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>43x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c) <i>Hypertensive Cardiovascular Disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i> <i>6 yrs.</i> <i>6 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>17 June 1957</i> , to <i>18 June 1957</i> , that I last saw the deceased alive on <i>17 June 1957</i> , and that death occurred <i>7:50 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Klaus H. Huebner</i> M.D.		ADDRESS (Street, city or town, state) <i>North East, Md</i>	
PHYSICIAN'S NAME (Type) <i>Klaus H. Huebner M.D.</i>		DATE SIGNED <i>18 June '57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>6-21-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt Zoar</i>	22d. LOCATION (City, town, or county) (State) <i>Conowingo, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leeva Patterson & Son</i>		24a. REC'D BY REGISTRAR <i>Leeva Patterson & Son</i>	
ADDRESS <i>Ferryville, Md.</i>		24b. REGISTRAR'S SIGNATURE	

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JUN 24 1957
BUREAU V. S.

6222

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 30 yrs. 3 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1233 Salem Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN		First T.		Middle HYNES		Last	
4. DATE OF DEATH Month June		Day 26		Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-21-83		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, left lower lobe						INTERVAL BETWEEN ONSET AND DEATH 4-5 days	
420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease, severe						unknown	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema, bilateral, severe - unknown. Arteriosclerosis, general, severe						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 491x					
20c. TIME OF INJURY Hour a. j. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 26 , 19 57 , to June 26 , 19 57 , and that death occurred at 6:55 p.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. A. Oppler				DATE SIGNED 6-28-57			
PHYSICIAN'S NAME (Type) W. A. OPPLER				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-27-57		22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Perkinson & Son				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE 6-28-57	
				24b. REGISTRAR'S SIGNATURE James E. Linder			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1937

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6223

CERTIFICATE OF DEATH

06209

Reg. Dist. No. 93

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East				c. LENGTH OF STAY IN 1b 21 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary L. Johnson				4. DATE OF DEATH Month Day Year June 29 19 57			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 6, 1879	
9. AGE (In years last birthday) yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME William Cole				14. MOTHER'S MAIDEN NAME Emmaline-?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Lelia Landram-North East, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Congestion of left Foot DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 months 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 1. April 1957, to 29 June 1957, that I last saw the deceased alive on 22 June 1957, and that death occurred at 4:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Hubner				ADDRESS (Street, city or town, state) North East, Md.		DATE SIGNED 29 June '57	
PHYSICIAN'S NAME (Type) Klaus H. Hubner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/57		22c. NAME OF CEMETERY OR CREMATORY Griffin Cemetery		22d. LOCATION (City, town, or county) (State) Cedar Hill, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Bell				ADDRESS 909 Poplar St., Wiln.		24a. REC'D BY REGISTRAR DATE 7/3/57	
				24b. REGISTRAR'S SIGNATURE J.R. Frazer			

BUREAU V. S.

1917

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6224

CERTIFICATE OF DEATH

Reg. Dist. No.

06210

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit, Md.</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>E.</u> Last <u>Krauss</u>				4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>19 57</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 20, 1883</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Abraham Jasson</u>			
14. MOTHER'S MAIDEN NAME <u>Sarah Kelly</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Chester Krauss, Jr. Port Deposit, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis -</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Aug 1954</u> to <u>June 11, 1957</u> , that I last saw the deceased alive on <u>June 11, 1957</u> , and that death occurred at <u>11:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clarence J. Benson</u> M.D.				ADDRESS (Street, city or town, state) <u>Port Deposit, Md.</u>			
DATE SIGNED <u>6/13/57</u>				PHYSICIAN'S NAME (Type) <u>Dr. C. I. Benson, Port Deposit, Maryland.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 14, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hoswell Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Port Deposit, RD., Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. W. Patterson, Jr.</u>				ADDRESS <u>Perryville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>June 14, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>John S. Langley</u>							

BUREAU V. 3

JUN 17 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6201 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06211

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b All life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Elston Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William A Lair				4. DATE OF DEATH Month Day Year 6 3 19 57			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5 1869	
9. AGE (In years last birthday) 88 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen. Labor				10b. KIND OF BUSINESS OR INDUSTRY General Labor			
11. BIRTHPLACE (State or foreign country) Cecil Co. Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME R Benjamin Lair				14. MOTHER'S MAIDEN NAME Mary Jane Rittenhouse			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. -----			
17. INFORMANT Wm Lushy, Elkton, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture base of Skull 900-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down cellar steps			
20c. TIME OF INJURY Month, Day, Year Hour m. 5-31-57				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home				20f. (City or town) Elkton (County) Cecil (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6-5-57			
22c. NAME OF CEMETERY OR CREMATORY Zion				22d. LOCATION (City, town, or county) North East R.D. Md. (State)			
22e. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR 6/5/57			
Elkton, Md.				24b. REGISTRAR'S SIGNATURE			

BUREAU V. S.

JUN 6 1961

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06212

6225

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 15yrs.3mo.6days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norfolk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1118 Rodgers		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First David Middle C. Last Langhorne		4. DATE OF DEATH Month June Day 18 Year 19 57					
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-?-93	9 AGE (In years lost birthday) 63 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia, unresolved, right lower lobe DUE TO (b) Coronary heart disease, severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Tuberculosis, pulmonary, inactive (clinical) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, general, severe - unknown							INTERVAL BETWEEN ONSET AND DEATH 7-10 days unknown unknown YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 57		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 12, 1942, to June 18, 1957, and that death occurred at 10:20 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Oppler		M.D. V.A. Hospital, Perry Point, Md.		DATE SIGNED 6-18-57			
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 6-18-57		22c. NAME OF CEMETERY OR CREMATORY Forest Lawn		22d. LOCATION (City, town, or county) (State) Norfolk, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.				24a. REC'D BY REGISTRAR DATE 6-19-57		24b. REGISTRAR'S SIGNATURE J. E. Douglas	

BUREAU V. S.

JUN 11 1957

RECEIVED

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06213

6202

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 19 yrs in Co.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital D.O.A.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles William Laramore				4. DATE OF DEATH Month 6- Day 25 Year 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-11-1894		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Ret.		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Church Hill. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Wm. Laramore				14. MOTHER'S MAIDEN NAME Clough			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes.		16. SOCIAL SECURITY NO. 221-10-2271		17. INFORMANT Address Charles Laramore, Charlestown. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-29-1957		22c. NAME OF CEMETERY OR CREMATORY Charlestown Cemetery		22d. LOCATION (City, town, or county) (State) Charlestown Md	
23. FUNERAL DIRECTOR'S SIGNATURE Dr. Henry Pippin				24a. REC'D BY REGISTRAR DATE 6-25-57		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

JUN 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the General Director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6226 CERTIFICATE OF DEATH

06256
96

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1903-15th Street, N.W.	
3. NAME OF DECEASED (Type or print) First MIDDLE Last FREDERICK (NLI) LE COUNTÉ		4. DATE OF DEATH Month Day Year June 30 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-12-89
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		9b. AGE (In years last birthday) 67 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Window Washer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel LeCounte		14. MOTHER'S MAIDEN NAME Florida Dulaney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) Yes		16. SOCIAL SECURITY NO. 578-12-1158	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Edema pulmonary acute due to Pancreatitis 4200 DUE TO hemorrhagic (cause unknown) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease severe DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 - 3 hours unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 27, 1957, to June 30, 1957, and that death occurred at 7:25 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 7-2-57			
ACTUAL SIGNATURE W. A. Hospital		M.D. V.A. Hospital, Perry Point, Md. 7-2-57	
PHYSICIAN'S NAME (Type) W. A. Hospital		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 7-2-57	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Sons		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR DATE 7-5-57		24b. REGISTRAR'S SIGNATURE Irene E. a Long Lady	

BUREAU V. S.

JUL 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06214

6227

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital			d. STREET ADDRESS 1801 Warwick Avenue		
3. NAME OF DECEASED (Type or print) First CHARLES Middle J. Last MATHEWS			4. DATE OF DEATH Month June Day 3 Year 19 57		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-23-14	9. AGE (In years lay birthday) 43 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Michigan	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Creasie (?) Barnes		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Obstruction of the intestines due to infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Infarction of the myocardium due to unknown cause DUE TO (c) Myocarditis of unknown cause					INTERVAL BETWEEN ONSET AND DEATH 7-10 days unknown unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ulcers, gastric, multiple - Unknown					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. VA 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from May 21 , 19 57 , to June 3 , 19 57 , and that death occurred at 12:50 P.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE W. Oppier		M.D. V.A. Hospital, Perry Point, Md.		DATE SIGNED 6-5-57	
PHYSICIAN'S NAME (Type) W. OPIER		Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 6-5-57	22c. NAME OF CEMETERY OR CREMATORY Moss Grove		22d. LOCATION (City, town, or county) (State) Louisiana	
23. FUNERAL DIRECTOR'S SIGNATURE Peppington & Son, Inc.		ADDRESS St. Louis de Grace, Md.		24a. REC'D BY REGISTRAR DATE 6-6-57	24b. REGISTRAR'S SIGNATURE J. E. Longfellow

RECEIVED

JUN 7 1957

BUREAU V. S.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6228 CERTIFICATE OF DEATH

06215
96

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Perryville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Katherine A. McVey				4. DATE OF DEATH Month Day Year June 17 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1858		9. AGE (In years last birthday) 98 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nathan McVey				14. MOTHER'S MAIDEN NAME Elizabeth ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Harry W. Gallion, Perryville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 400.0 DUE TO Cerebral Sclerosis - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis (c)						INTERVAL BETWEEN ONSET AND DEATH 6 months - 9 yrs -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocarditis -						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 10, 1957, to June 16, 1957, that I last saw the deceased alive on June 16, 1957, and that death occurred at 11:00 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Clarence I. Benson M.D.				ADDRESS (Street, city or town, state) Port Deposit, Md. DATE SIGNED 6/17/57			
PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/20/57		22c. NAME OF CEMETERY OR CREMATORY Harmony Chapel		22d. LOCATION (City, town, or county) (State) Liberty Grove, Cecil, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Lee A. Patterson & Son Perryville, Maryland				24a. REC'D BY REGISTRAR DATE 6-20-57		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

JUN 11 1957

RECEIVED

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

RECEIVED

7. 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6203

CERTIFICATE OF DEATH

06217

Reg. Dist. No

92

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS /			
3 NAME OF DECEASED (Type or print) First Middle Last ANDREW F. MOORE				4. DATE OF DEATH Month Day Year June 30 1957			
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 31, 1881		9 AGE (In years lost birthday) 76 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Weaver		10b KIND OF BUSINESS OR INDUSTRY Textile Mfg.		11. BIRTHPLACE (State or foreign country) North East Maryland		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Moore				14. MOTHER'S MAIDEN NAME Rebecca Atkinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO. 215-09-8862		17. INFORMANT Address Alice R. Moore (Wife) Elk Mills, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Arteriosclerotic cardio-vascular disease with congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							INTERVAL BETWEEN ONSET AND DEATH unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 5 1957, to June 30 1957, that I last saw the deceased alive on June 30 1957, and that death occurred at 2:35 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews, Jr.				ADDRESS (Street, city or town, state) 233 East Main Street		DATE SIGNED 6/30/57	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. Elkton, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 3, 1957		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cecil County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks				ADDRESS Elkton, Maryland		24a. REC'D BY REGISTRAR DATE 7/1/57	
				24b. REGISTRAR'S SIGNATURE			

BUREAU V. S.

MAY 5 1957

RECEIVED

6230 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRIDNARY PT</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>PA</u> b. COUNTY <u>CHESTER</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENNETT SQUARE</u> d. STREET ADDRESS <u>400 CENTER ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>KERRY</u> First <u>PATRICK</u> Middle <u>O'NEILL</u> Last 4. DATE OF DEATH Month <u>6</u> Day <u>30</u> Year <u>1957</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jul 20, 1948</u> 9. AGE (In years last birthday) <u>9</u> yrs. 10. IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> 11. IF UNDER 24 HRS. Hours <u>10</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>STUDENT</u> 11. BIRTHPLACE (State or foreign country) <u>PENNA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOHN H O'NEILL</u> 14. MOTHER'S MAIDEN NAME <u>CATHERINE CERRA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>ALLEN C BARR WELLS, KENNETT SQ</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNED</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Stepped off Sand Bar in Sasapass River</u> 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>2:30</u> a. m. <u>6:30</u> p. m. <u>1957</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Sasapass River</u> 20f. (City or town) <u>Ordinary Pt Cecil Md</u> (County) <u>Cecil</u> (State) <u>MD</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>RC Dodson</u> EXAMINER'S NAME (Type) <u>RC Dodson</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7-3-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried July 5, 1957 St. Patrick's</u> 22b. DATE THEREOF <u>July 5, 1957</u> 22c. NAME OF CEMETERY OR CREMATORY <u>KENNETT SQUARE PA.</u> 22d. LOCATION (City, town or county) <u>PA.</u> (State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Edward Culshaw Millington Md.</u> ADDRESS <u>—</u> 24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUL 8 '57</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal

BUREAU V. S.

JUL 8 196

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10045 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11809

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Indiana			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 11yrs5mos29days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Blairsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 415 N. Spring St.			
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-around;"> First WILBUR Middle C Last POLLOCK </div>				4. DATE OF DEATH <div style="display: flex; justify-content: space-around;"> Month June Day 19 Year 1957 </div>			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH May 10, 1902		9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days 			
11. IF UNDER 24 HRS Hours Min. 		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal			
11. BIRTHPLACE (State or foreign country) Rochester, Penna.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Melvin Pollock			
14. MOTHER'S MAIDEN NAME Mildred Cochran		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Hospital Records, VAH., Perry Point, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heat Exhaustion 931.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <div style="display: flex; justify-content: space-between;"> Hour o. m. p. m. 19 </div>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 			
20f. (City or town) 		20g. (County) 		20h. (State) 			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE R. C. DODSON		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11-17-57			
NAME (Type) R. C. DODSON, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Removal					
22b. DATE THEREOF 11-17-57		22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) Blairsville, Penna.			
23. FUNERAL DIRECTOR'S SIGNATURE PENNINGTON A. SON, Harry eGrace, Md.		24a. REC'D BY REGISTRAR DATE 11-17-57		24b. REGISTRAR'S SIGNATURE Gene E. Daugherty			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

BUREAU V. S.

NOV 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06218

Item 9, Film G217, 6/21/57 for

CERTIFICATE OF DEATH

Reg. Dist. No. 96

6231

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMORY Middle P. Last RECTOR		4. DATE OF DEATH Month June Day 13 Year 1957	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-10-86
9. AGE (In years last birthday) 70 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME T. P. Rector		14. MOTHER'S MAIDEN NAME Mary Ella (R) Rector Bonham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Peace Time		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, uremic poisoning 7.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypoplasia at the right kidney DUE TO (c) Absence of the left kidney acquired 6-4-57			INTERVAL BETWEEN ONSET AND DEATH 7 days unknown 6-4-57
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, general, moderate - unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> al work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 28, 1950, to June 13, 1957, and that death occurred at 1:02 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 6-14-57	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 6-14-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
Arlington Funeral Home, Arlington, Va.		DATE JUN 18 1957	

BUREAU V. S.

JUN 18 1957

RECEIVED

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6232

06219

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton RDI				c. LENGTH OF STAY IN 1b 2 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS Elkton, R.D.1			
3. NAME OF DECEASED (Type or print) Elsie Ann Rice				4. DATE OF DEATH Month 6 Day 2 Year 19 57			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1908		9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Keeping House		11. BIRTHPLACE (State or foreign country) Cecil Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Walter Hickman			
14. MOTHER'S MAIDEN NAME Lula Barrow				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. -----				17. INFORMANT Walter Rice, Elkton, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Uterus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> R.C. Dodson M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6-3-57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-4-1957		22c. NAME OF CEMETERY OR CREMATORY Elkton Manor Memorial		22d. LOCATION (City, town, or county) (State) Elkton Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Poffin ADDRESS Elkton Md.				24a. REC'D BY REGISTRAR 6/5/57 DATE		24b. REGISTRAR'S SIGNATURE J. R. J.	

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JUN 6 1967

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6233

CERTIFICATE OF DEATH

Reg. Dist. No.

06220
76

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rowlandville</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Richard Rofka</u>		4. DATE OF DEATH <u>6</u> <u>28</u> <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 11, 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Landscape Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert F. Rofka</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Lunther</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Eleanor L. Rofka</u>		Address <u>Rowlandville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Sclerosis -</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-Sclerosis -</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 8, 1957</u> to <u>June 27, 1957</u> , that I last saw the deceased alive on <u>June 27 - 1957</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clarence I. Benson</u> M.D.		ADDRESS (Street, city or town, state) <u>Port Deposit, Md.</u>	
PHYSICIAN'S NAME (Type) <u>CLARENCE I. BENSON</u>		DATE SIGNED <u>June 29, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-1-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ashurst</u>	22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son, Perryville, Md.</u>		24a. REC'D BY REGISTRAR <u>6-27-57</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

1907

RECEIVED

THIS MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6234

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06221

Reg. Dist. No. 94

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY Chester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) just for day Coatsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Murphy Shore		d. STREET ADDRESS 803 E. Main St.	
3. NAME OF DECEASED (Type or print) First Middle Last Arthur Linton Sherill		4. DATE OF DEATH Month 6 Day 19 Year 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-25-1943
9. AGE (In years last birthday) 13 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Coatsville, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Linton Sherill		14. MOTHER'S MAIDEN NAME Frances Harnish	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Arthur L. Sherill		Address 803 E. Main Coatsville, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned 7.2.9.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Was in river N. East and raft was floating a way.	
20c. TIME OF INJURY Month, Day, Year Hour 12:45 p.m. 6-19-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N. E. River		20f. (City or town) Charlestown Cecil Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-22-1957	
22c. NAME OF CEMETERY OR CREMATORY Fairview		22d. LOCATION (City, town, or county) Coatsville Chester Co. Pa. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		ADDRESS North East Md	
24a. REC'D BY REGISTRAR DATE 6-21-57		24b. REGISTRAR'S SIGNATURE Sarah E. Rothermel	

DATE SIGNED

6-20-57

RECEIVED
JUN 1 1964
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6204

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07368

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 14 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 123 Bells Lane				d. STREET ADDRESS 123 Bells Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Emma Smith				4. DATE OF DEATH Month Day Year 6 11 19 57			
5. SEX F		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-24-1909	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY General House		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Smith				14. MOTHER'S MAIDEN NAME Mattie May Holland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Mattie M. Thompson, 115 Bells Lane Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis and hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 441X 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. Dodson				DATE SIGNED 6-11-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/14/57		22c. NAME OF CEMETERY OR CREMATORY St. Thomas Cem.		22d. LOCATION (City, town, or county) (State) Glasgow, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Bell				ADDRESS Wilmington, Delaware		24a. REC'D BY REGISTRAR DATE 12-19-57	
						24b. REGISTRAR'S SIGNATURE J. R. Taylor	

RECEIVED

JUL 18 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the bur-ol-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6205

CERTIFICATE OF DEATH

06222

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <u> Cecil </u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u> Md </u> b. COUNTY <u> Cecil </u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u> Elkton </u>		c. LENGTH OF STAY IN 1b <u> 9 days </u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u> Union Hospital </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u> William </u> Middle <u> M. </u> Last <u> Smith </u>		4. DATE OF DEATH Month <u> June </u> Day <u> 2 </u> Year <u> 1957 </u>	
5. SEX <u> Male </u>	6. COLOR OR RACE <u> White </u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u> Sept. 5, 1882 </u>
9. AGE (In years last birthday) <u> 74 </u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> Laborer </u>		10b. KIND OF BUSINESS OR INDUSTRY <u> Way Laborer </u>	
11. BIRTHPLACE (State or foreign country) <u> Md. </u>		12. CITIZEN OF WHAT COUNTRY? <u> U.S.A. </u>	
13. FATHER'S NAME <u> Charles L. Smith </u>		14. MOTHER'S MAIDEN NAME <u> Sarah McMass </u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> No. </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u> Mrs Charles E. Bridge </u>		Address <u> Port Deposit, Md </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u> Arteriosclerotic C-V Disease with congestive heart failure and atricular fibrillation </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u> unknown </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> Emphysema, malnutrition </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> 19 </u> p. m. <u> </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u> May 24, 1957 </u> to <u> June 2, 1957 </u> , that I last saw the deceased alive on <u> June 2, 1957 </u> , and that death occurred at <u> 11:20 AM </u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u> S. Ralph Andrews, Jr. </u> M.D.		ADDRESS (Street, city or town, state) <u> 233 E. Main Street </u> DATE SIGNED <u> 6/2/57 </u>	
PHYSICIAN'S NAME (Type) <u> S. RALPH ANDREWS, JR., M.D. </u> <u> Elkton, Maryland </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u> Burial </u>	<u> 6-4-1957 </u>	<u> Hopewell Cemetery </u>	<u> Port Deposit, Md. Rural </u>
23. FUNERAL DIRECTOR'S SIGNATURE <u> Lee A. Patterson & Son, Perryville, Md. </u>		24a. REC'D BY REGISTRAR DATE <u> 6/7/57 </u>	
24b. REGISTRAR'S SIGNATURE			

RECEIVED

JUN 5 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06223

6235

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN 1b 5yrs.3mo.11days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1400 Ohio Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED First Middle Last GEORGE E. SOPER				4. DATE OF DEATH Month Day Year June 12 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-20-16		9. AGE (In years lost birthday) yrs 40	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10b. KIND OF BUSINESS OR INDUSTRY Service Station		11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Guy Soper				14. MOTHER'S MAIDEN NAME Alice Fridley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cellulitis of neck, massive, secondary to laryngectomy and radical neck operation for carcinoma DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work et work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1, 1952, to June 12, 1957, and that death occurred at 11:10 P.M. from the causes and on the date stated above							
ACTUAL SIGNATURE W. Oppler		ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 6-14-57					
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-14-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Bennington & Son				ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 6-14-57	
				24b. REGISTRAR'S SIGNATURE Irene E. Montgomery			

RECEIVED

JUN 18 1957

BUREAU W

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6236

CERTIFICATE OF DEATH

Reg. Dist. No.

06224

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 4423 - 15th Street, N.W.	
3. NAME OF DECEASED (Type or print) First RICHARD Middle Last SPENCER JR.		4. DATE OF DEATH Month June Day 12 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-31-82
9. AGE (In years last birthday) yrs. 75		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter - Retired		10b. KIND OF BUSINESS OR INDUSTRY Pullman	
11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Spencer		14. MOTHER'S MAIDEN NAME Ellen Mundy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO (If yes, give war or dates of service) S.A.W. 708 12 4883	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, uremic poisoning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephrosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. VA 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 23 , 19 57 , to June 12 , 19 57 , and that death occurred at 5:45 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		ADDRESS (Street, city or town, state) DATE SIGNED M.D. V.A. Hospital, Perry Point, Md. 6-13-57	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 6-12-57	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Bennington & Son		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR DATE 12-13-57		24b. REGISTRAR'S SIGNATURE J. H. Hargrave	

BUREAU V. S.

1957 12 17

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6237

CERTIFICATE OF DEATH

06225

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Robert Lewis Stebbing				4. DATE OF DEATH Month Day Year June 2 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 14, 1868	
9. AGE (In years last birthday) 88 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY General Store		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George H. Stebbing		14. MOTHER'S MAIDEN NAME Margaret Whalen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 218-34-2208		17. INFORMANT Address Alberta Barr, Port Deposit, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerosis -</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>8 yrs.</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Prostate -</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Port Deposit				20g. (County) Md.		20h. (State) Md.	
21. I certify that I attended the deceased from Jan 2, 1956 to June 2, 1957, that I last saw the deceased alive on June 2, 1957, and that death occurred at 3:40 p.m., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clarence I. Benson</u> M.D.				DATE SIGNED <u>6/3/57</u>			
PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 5, 1957		22c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		22d. LOCATION (City, town, or county) (State) Port Deposit, Md., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son</u>				ADDRESS Box 188, Perryville, Md.		24a. REC'D BY REGISTRAR DATE June 6, 1957	
				24b. REGISTRAR'S SIGNATURE <u>James E. Montgomery</u>			

BUREAU V. M.

JUN 7 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

JUN 14 1957

RECEIVED

6239

CERTIFICATE OF DEATH

Reg. Dist. No.

06227

75

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) o STATE <u>Maryland</u> b COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CALVERT MD</u>		c. LENGTH OF STAY IN 1b <u>4 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital/give street address) OR INSTITUTION <u>Greybeal Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles R Stewart</u>		4. DATE OF DEATH <u>June 13 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12 1882</u>
9. AGE (In years last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>4</u> Hours <u>13</u> Min <u>57</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm Stewart</u>		14. MOTHER'S MAIDEN NAME <u>Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>LAWRENCE F Stewart, Bristol PA</u>		Address <u>---</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> DUE TO <u>Cerebrovascular accident</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <u>arteriosclerosis</u> (c) <u>---</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 days</u> <u>12 hours</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>---</u> p. m. <u>---</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>
20f. (City or town) <u>---</u>		(County) <u>---</u> (State) <u>---</u>	
21. I certify that I attended the deceased from <u>5/25 1957</u> to <u>6/13 1957</u> that I last saw the deceased alive on <u>6/12 1957</u> and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil Taylor Jr</u>		DATE SIGNED <u>6/16/57</u>	
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr</u>		ADDRESS (Street, city or town, state) <u>---</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-17-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rosebank</u>	22d. LOCATION (City, town, or county) <u>Calvert Cecil County</u> (State) <u>Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R GRANT</u>		ADDRESS <u>North East, Md</u>	
24a. REC'D BY REGISTRAR <u>---</u>		24b. REGISTRAR'S SIGNATURE <u>---</u>	

MEDICAL CERTIFICATION

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 18 1957

BUREAU V. S.

06228

6206

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		d. STREET ADDRESS <u>RD #1</u>	
3. NAME OF DECEASED (Type or print) <u>EMMETT FRANKLIN STURGILL</u>		4. DATE OF DEATH <u>June 21 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Steve Sturgill</u>		14. MOTHER'S MAIDEN NAME <u>AMANDA PERKINS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>245-14-0424</u>	
17. INFORMANT <u>James Sturgill</u>		Address <u>ELKTON RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage with hemiplegia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 19</u> , 19 <u>57</u> , to <u>June 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 21</u> , 19 <u>57</u> , and that death occurred at <u>5:45 p. m.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>S. Ralph Andrews, Jr.</u> M.D. <u>233 East Main Street</u>		<u>6/21/57</u>	
PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u>		<u>Elkton Maryland</u>	
22a. REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/23/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GILPIN MANOR MEM. PARK</u>		22d. LOCATION (City, town, or county) (State) <u>CECIL MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Walter duBois, Jr.</u> ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR. DATE <u>5/26/57</u>	
24b. REGISTRAR'S SIGNATURE <u>TH. J. C.</u>			

BUREAU V. S.

JUN 28 1957

RECEIVED

6207

CERTIFICATE OF DEATH

07373

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ecil</u> <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elk Neck</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union</u>		d. STREET ADDRESS <u>none</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Wall</u>		4. DATE OF DEATH Month <u>6</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/24/57</u>
9. AGE (In years last birthday) yrs. <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Elkton</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Angela R. Wall</u>		14. MOTHER'S MAIDEN NAME <u>Maurin Lloyd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Maurin Wall</u>		Address <u>Elk Neck, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>751x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congenital Anomaly</u> (c) <u>(Meningocele)</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Clifton R. Brink</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7/12/57</u>	<u>Bellin Memorial</u>	<u>Bellin Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard W. Howard</u>		24a. REC'D BY REGISTRAR DATE <u>7-12/57</u>	24b. REGISTRAR'S SIGNATURE <u>John - E. L. ...</u>

BUREAU Y. S.

APR 16 1957

RECEIVED

6240

CERTIFICATE OF DEATH

06229

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 3mos. 25days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 3144 Q St., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK WALLING		4. DATE OF DEATH Month Day Year June 7 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-9-1889
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. Walling		14. MOTHER'S MAIDEN NAME Mary McKeever	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) due to Atherosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 331x		INTERVAL BETWEEN ONSET AND DEATH 24 hours Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. VA 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 12 , 1957, to June 7 , 1957, and that death occurred at 11:20A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED W. A. Hospital, Perry Point, Md. 6-9-57			
ACTUAL SIGNATURE W. Opler		M.D. V. A. Hospital, Perry Point, Md. 6-9-57	
PHYSICIAN'S NAME (Type) W. OPLER		Director Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 6-9-57	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Ft. Myer, Va.
23. FUNERAL DIRECTOR'S SIGNATURE BENJAMIN L. LONG		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR DATE 6-9-57		24b. REGISTRAR'S SIGNATURE Lena E. Shougherty	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 11 1957

RECEIVED

6208

CERTIFICATE OF DEATH

Reg. Dist. No.

06230

1. PLACE OF DEATH a. COUNTY CECIL ELKTON, MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 15 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 355 W. Main St				e. STREET ADDRESS 355 West Main Street			
3. NAME OF DECEASED (Type or print) First OLGA Middle WIDDOES Last WIDDOES				4. DATE OF DEATH Month June Day 17 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 24, 1893	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 6 Days 17 Hours 19 Min.		IF UNDER 24 HRS. Months 6 Days 17 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY House Work		11. BIRTHPLACE (State or foreign country) Konesha, Wisconsin	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Roy Olsen				14. MOTHER'S MAIDEN NAME No information			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Thomas M. Widdoes				Address 355 W. Main St. Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart disease DUE TO 0 (c) 0							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 72 hours							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1953 to June 17, 1957 that I last saw the deceased alive on June 16, 1957 , and that death occurred at 10:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 135 W. Main, Seely, Md. DATE SIGNED June 18, 1957							
ACTUAL SIGNATURE Orford H. Sprecher, M.D.							
PHYSICIAN'S NAME (Type) Orford H. Sprecher							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-20-1957		22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memo Pk.		22d. LOCATION (City, town, or county) (State) R. D. Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Phipps				24a. REC'D BY REGISTRAR DATE 6/21/57		24b. REGISTRAR'S SIGNATURE W. H. Phipps	

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 24 1957

RECEIVED